New York's Section 1115 Family Planning Proposal
CMS Questions/Comments and State's Follow-up Responses

Section III.B. – Project Design - Target Population

1. CMS Original Question: Please provide an estimate of how many women, men and teens are in the target population and are potentially eligible for the demonstration. In addition, please further explain, and if needed, revise the enrollment projections. In the budget neutrality section, the State estimates that 13,440 women will enroll in the program. This number seems exceptionally low and does not account for enrollment among men. (Page 8-9)

   State verbal response on 6/8/01: This estimate was deliberately conservative. Counties are responsible for administering much of the Medicaid program in New York. The State will promote the family planning expansion to counties but cannot mandate facilitated enrollment. "Facilitated enrollment" is a New York term for counties entering into agreements with entities to facilitate enrollment into a Medicaid program.

   CMS Response in 1/30/02 Letter: The State's response only partially addresses the question. Please address the question with respect to potential eligibles and enrollment projections.

   State response 5/2002:

   The potential eligibles, based on the 1996 Vital Statistics and Current Population Survey of men and women, ages 15-45 and within 100-200% of the federal poverty level, are approximately 772,000. This figure will be adjusted as a result of the phase-in of New York State's Family Health Plus Program, which was implemented in October 2001. This health insurance program provides health benefits to single and married adults, 19-64, who are up to 150% of the federal poverty level. The State estimates that 18,000 men and women will initially enroll in the family planning expansion program. There is currently no State legislative authority to require counties to provide facilitated enrollment for this Medicaid waiver program. However, the Department will actively encourage local social services districts to use local county health departments, publicly supported family planning clinics, and Prenatal Care Assistance Program (PCAP) providers to assist clients in completing the simplified application. In many cases, this will eliminate the requirement for a face-to-face interview in a local social services district office. All applications taken at these sites will be forwarded to the local social services district for final eligibility determinations.

3. CMS Original Question: The State currently makes SOBRA women, whose Medicaid eligibility expires after two months postpartum, eligible for family planning services through its current section 1115 demonstration called the "Partnership Plan." Does the State want to have two separate programs offering family planning services or shift the population under the family planning demonstration into the Partnership Plan?

State verbal response on 6/8/01: The State wants to continue to pursue a separate family planning section 1115 demonstration.

CMS response in 1/30/02 Letter: CMS urges the State to expand family planning services by amending its existing section 1115 demonstration – The Partnership Plan. If the State still desires to pursue a separate family planning demonstration, please explain why.

State response 5/2002:

We agree to amend the State's existing 1115 waiver demonstration -- The Partnership Plan – to include expanded family planning services.

Section III.C. – Project Design - Eligibility for Family Planning Expansion Program

6. CMS Original Question: Since family planning services are covered under the Child Health Plus (CHP) program, will teens who are eligible for or enrolled in CHP be excluded from enrollment in the family planning demonstration? Will teenage applicants be automatically screened for CHP eligibility in addition to Medicaid eligibility? If so, how will this process work? (Page 10)

State verbal response on 6/8/01: Teens in CHP will also be eligible for the family planning demonstration. If they go to the family planning expansion because they are uncomfortable with getting family planning in CHP, the State will also enroll them in the family planning demonstration. The State will find some way to recoup duplicate payments. Teens who apply for family planning will also be screened for CHP and Medicaid.

CMS response in 1/30/02 Letter: Teens who are enrolled in CHP must receive services through that program. A state can not enroll an individual into more than one program (i.e., CHP, family planning demonstration, or the Partnership Plan). Duplicate payments are not allowed. It is our understanding that New York has very strict confidentiality protections already in place. If this is not the case, please clarify using specific examples why the State thinks that enrollees in CHP would need to have access to services under the family planning demonstration. Also, please explain how the process for screening teenage applicants for CHP eligibility in addition to Medicaid eligibility will work.

State response 5/2002:

Teens enrolled in CHP will not be excluded from enrollment in the family planning expansion waiver program. Under Social Services Law section 366(1)(a)(11), all persons who are not otherwise eligible for medical assistance and whose income is below 200% FPL are eligible to receive family planning benefits under the family planning expansion waiver program. State law does not authorize excluding individuals on the basis of enrollment in CHP or other health insurance coverage.

In addition, for purposes of CHP eligibility under Title XXI which excludes children eligible for or potentially eligible for Medicaid from enrollment, federal regulations at 42 CFR 457.310(b)(3) state that "Medicaid eligibility" includes 1115 waivers OTHER THAN waivers that do not provide inpatient hospital coverage. Therefore, because the family planning expansion waiver program does not include coverage for inpatient hospital care, children enrolled in the family planning program may also enroll in CHP. The State does not believe claiming is an issue. The permissibility of dual enrollment under this federal regulation implies the permissibility of claiming under each program.

8. CMS Original Question: The State indicates that eligibility for teens will be based upon their own income. However, at the time teens are screened for the family planning demonstration, they will also be screened for Medicaid. Since eligibility for Medicaid is based upon family income, how will the State appropriately screen teens for eligibility for Medicaid, particularly if a simplified application will be used? (Page 10)

   State verbal response on 6/8/01: [Not sure if the State was asked this question previously]

   CMS response in 1/30/02 Letter: Please answer the above question regarding differing income standards.

   State response 5/2002:

   If teens are living with their parents, the person taking the application will explain to the teen that if they want full Medicaid, their parents' income (and resources, if applicable) will be counted, and if they are applying for the Family Planning Expansion Waiver program, their parental income will not be required. If they are requesting confidentiality, in most cases, it will not be possible to verify family income. Therefore, in this instance, eligibility for the Family Planning Expansion waiver can be determined using the teen's income (and resources, if applicable). If teens are not living with their parents, Medicaid eligibility will be determined using current procedures (determining eligibility for full Medicaid first using the teen's income without the parental income).

   The income of a minor who wants Family Planning Services will be compared to 200% of the Federal Poverty Level only after checking their income against following other income standards:

   - For individuals under age 19: Low Income Families (parallels ADC cash assistance program budgeting methodology of July 16, 1996); Medically Needy; and Expanded Eligibility (100% of the federal poverty level (FPL) through March 31, 2002; 133% FPL effective April 1, 2002).
   - For individuals ages 19 and 20: Low Income Families; Medically Needy; and

Family Health Plus (gross income 100% FPL for 19 and 20 year olds living on their own who are singles or childless couples, or 133% FPL -- to be raised to 150% of the FPL effective October 1, 2002 -- for 19 and 20 year olds living with their parents or who are parents themselves).

9. CMS Original Question: Will the screen for Medicaid eligibility be automatic, or will individuals be asked to affirmatively request that they be screened for Medicaid eligibility? If the process is not automatic, what steps will the State take to ensure that individuals are enrolled in the right program? (Page 10)

   State verbal response on 6/8/01: The screen will not always be automatic.

   CMS response in 1/30/02 Letter: If the process is not automatic, what steps will the State take to ensure that individuals are enrolled in the right program?

   State response 5/2002:

   Initial screening might not be automated – i.e., computerized. However, the process would always be "automatic," in that staff who take applications are trained to screen applicants for the appropriate program and assist in the completion of the application. We plan to build on the current joint application, "Access NY Health Care." This application is for Medicaid, Family Health Plus, Child Health Plus, Prenatal Care for Pregnant Women and WIC. In addition, the "Health Insurance Eligibility Screening Worksheet" is a screening tool to assist staff to assess an applicant's potential eligibility for various programs. This form will also be revised to include the Family Planning Services program.

15. CMS Original Question: Will individuals with other insurance (besides Medicaid) be eligible for the family planning demonstration? (Page 10)

   State verbal response on 6/8/01: Yes, if the third party insurance does not cover family planning, or if the person does not want to access family planning services through their third party insurance because it would compromise their confidentiality.

   CMS response in 1/30/02 Letter: The State's response indicates that it would allow Medicaid to be the primary payer for family planning services in certain situations where an individual already has private coverage that includes family planning benefits. Please clarify specifically what type of situation would warrant Medicaid being the primary payer, since this typically is not allowable.

   In addition, the State should also confirm that the application for the family planning demonstration not only asks whether an applicant currently has private insurance coverage, but also what types of family planning benefits are offered through that coverage.

   State response 5/2002:

Yes, individuals with other insurance will be eligible for the family planning expansion waiver program because under Social Services Law section 366(1)(a)(11), all persons who are not otherwise eligible for medical assistance and whose income is below 200% FPL are eligible to receive family planning benefits under the family planning expansion waiver program. State law does not authorize excluding individuals on the basis of other health insurance coverage.

In accordance with federal and state regulations, Medicaid is the last dollar payer when other third party insurance is available. However, in accordance with 42 CFR 433.147, there are circumstances in which there may be "good cause" for a provider not to bill a third party resource. These circumstances involve situations when billing the third party resource could jeopardize the health, safety and/or confidentiality of the Medicaid recipient. These circumstances include, but are not limited to: individuals in domestic violence shelters, individuals with HIV disease, and teens who do not want their parents to know of the pregnancy/family planning services. "Good cause" will also be permitted in some instances when the policyholder is not a legally responsible relative (i.e., when a student over age 21 is on his/her parents' health insurance policy). These individuals or providers on their behalf may request "good cause" for not billing the third party resource. "Good cause" for not billing the third party resource will be determined by the Department of Health on a "case by case" basis. No providers will be given a blanket approval to forgo billing the third party resource. If the patient wants the service to remain confidential, the provider must contact the Department and ask for a determination of "good cause". If granted, the provider will be instructed to submit the claim directly to Medicaid. They will not be required to submit the claim to the third party resource.

On the application, the applicant is asked to identify all third party resources. However, we do not include a question on the application that asks the applicant to identify the type of family planning benefits available through their third party resource. We instruct providers to bill all third party resources prior to submitting a claim to Medicaid. If the third party insurance denies payment for the service (e.g., the third party resource does not cover certain types of family planning devices/services), the provider is instructed to bill Medicaid only after having received a denial from the third party resource. The provider must retain documentation of the denial in their records. The only exception to this requirement would be in the event that the provider/recipient believes that the "good cause" process should be employed, as described as above.

Section III.D. – Recipient Outreach Efforts

16. CMS Original Question: The asterisked footnote states that ex parte determinations will be done for individuals denied or terminated from Medicaid and/or Family Health Plus to determine eligibility in the Family Planning Expansion Program. During the New York Medicaid Welfare Reform Implementation Review, we found that ex parte reviews were not being done statewide. New York State staff acknowledged the

disparities and stated that they are reviewing the situation. Has the State resolved the situation? If not, please provide a description of the procedures for how ex parte reviews will be done statewide. (Page 12)

State verbal response on 6/8/01: When someone becomes ineligible, the eligibility system will do the review. The State will also do training of the staff who do temporary disability assistance and public assistance.

CMS response in 1/30/02 Letter: Please provide more details on how ex parte reviews will be done.

State response 5/2002:

Our eligibility systems are being programmed to determine Family Planning eligibility when individuals are determined ineligible for Medicaid or Family Health Plus, using information the individual has already supplied. The system extends Medicaid coverage, as appropriate, to individuals whose cash assistance cases are closed. The Client Notices System informs the individual that a separate determination will be done. The Department has conducted training to stress the importance of the separate determination process and ex parte reviews. In addition, the Department is working with the Office of Temporary and Disability Assistance to automate the process for referring applications for separate Medicaid determinations when cash assistance is denied.

Section III.G. – Provider Network

24. CMS Original Question: The State anticipates that publicly funded family planning clinics will be the primary source of services under this demonstration. How does the State plan to facilitate access to additional providers (i.e. not clinic based)? (Page 16)

State verbal response on 6/8/01: Please see response to question 18.

CMS response in 1/30/02 Letter: The State's response describes how non-clinic based providers will be informed about the family planning demonstration, but does not explain how providers will be recruited in order to increase the number of providers available for enrollees to access. Please explain how the State plans to recruit providers.

State response 5/2002:

The State will recruit new family planning practitioners through the Medicaid Update, and by working with provider associations.

Section V - Program Evaluation

26. CMS Original Question: The State needs to develop a more detailed evaluation design. Please identify who will have actual responsibility for development of an evaluation design and who will conduct the evaluation. Is it necessary to have a comprehensive evaluation each year? Instead, the State may want to consider a long-term evaluation with annual progress reports. In addition, please provide hypotheses that will be tested as well as the sources of data for each hypothesis (page 18)

    State verbal response on 6/8/01: The State will get back to us.

    CMS response in 1/30/02 Letter: State response is required on this question.

    State response 5/2002:

    When CMS first asked the question, New York was pursuing a stand-alone 1115 family planning expansion waiver. At CMS's recommendation, we are now amending our current 1115 Partnership Plan waiver to include the family planning expansion. In accordance with our current waiver program evaluation and reporting requirements, New York will submit progress reports to CMS periodically, as specified by CMS.

27. CMS Original Question: Objective IV is to decrease Medicaid costs, including costs for abortions. Since the Medicaid program is prohibited from paying for most abortions, please explain why these savings should be included among the objectives.

    State verbal response on 6/8/01: [Not sure if the State was asked this question previously]

    CMS Response in 1/30/02 Letter: State response is required on this question.

    State response 5/2002:

    The intended objective was to reduce unnecessary abortions, thus incurring State savings.

    Primary Care Requirements

29. CMS Original Question: The State's recently submitted response to this requirement is not acceptable. The State is required to meet with the Primary Care Associations about referring clients to their facilities for primary care services. The State must provide CMS with a letter from the Primary Care Associations indicating their support of the process for referring participants to FQHCs (RHCs) for primary care services. Please submit the required assurances.

State response 5/2002:

The requested letter is included in this package.

Medical Codes

30. CMS Original Question: CMS has the following comments on the codes submitted by the State.

    a) ICD-9 code 63.95 would only be eligible for the 90 percent match if accompanied by a family planning diagnosis code (V25 or V26).

    b) ICD Code 65.92 would never be eligible for the 90 percent match.

    c) HCPCS code 58770 would only be eligible for the 90 percent match if accompanied by a family planning diagnosis code.

    d) CPT code 58825 would never be eligible for the 90 percent match.

    e) Local codes 90061, 90072 and 90073, which appear to be for visits to urologists, would only be eligible for the 90 percent match, if there is a diagnosis code or some other evidence that the visit was primarily for family planning purposes.

    State response 5/2002:

    Our current family planning claiming complies with all federal requirements.